SERVICE DELIVERY. ADMINISTRATIVE AND OPERATIONAL REQUIREMENTS

A. Provision of Services

The Contractor shall provide, or arrange and pay for, covered services to beneficiaries, as defined for the purposes of this contract, of _____ County.

In determining whether a service is covered under this contract based on the diagnosis of the beneficiary, the Contractor may not exclude a beneficiary solely on the grounds that the provider making the diagnosis has used the International Classification of Diseases (ICD) diagnosis system rather than the system contained in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. For services provided pursuant to Section C, the Contractor will consider the following ICD-9 diagnoses codes as included. For any other service, the Contractor may consider these codes as included or may require the provider to use DSM IV.

Table 1 - Included ICD-9 Diagnoses - All Places of Services Except Hospital Inpatient

295.00 – 298.9	302.8 - 302.9	311 - 313.82
299.1 – 300.89	307.1	313.89 – 314.9
301.0 – 301.6	307.3	332.1 – 333.99 *
301.8 – 301.9	307.5 - 307.89	787.6
302.1 – 302.6	308.0 - 309.9	

*Note: Treatment of diagnoses 332.1 - 333.99, Medication Induced Movement Disorders, is a covered service only when the Medication Induced Movement Disorder is related to one or more included diagnoses.

Table 2 - Included ICD-9 Diagnoses - Hospital Inpatient Place of Service

290.12 – 290.21	299.10 - 300.15	308.0 – 309.9
290.42 – 290.43	300.2 - 300.89	311 – 312.23
291.3	301.0 - 301.5	312.33 - 312.35
291.5 - 291.89	301.59 - 301.9	312.4 – 313.23
292.1 - 292.12	307.1	313.8 – 313.82
292.84 – 292.89	307.20 - 307.3	313.89 - 314.9
295.00 – 299.00	307.5 - 307.89	787.6

B. Availability and Accessibility of Service

The Contractor shall ensure the availability and accessibility of adequate numbers of institutional facilities, service locations, service sites, and professional, allied and supportive personnel to provide medically necessary services, and ensure the authorization of services for urgent conditions on a one-hour basis.

C. Emergency Psychiatric Condition Reimbursement

The Contractor shall pay for services for emergency psychiatric conditions received by a beneficiary from providers, whether or not the provider has a subcontract with the Contractor. Such services will not be subject to prior authorization by the Contractor.

D. Organizational and Administrative Capability

The Contractor shall have the organizational and administrative capabilities to carry out its duties and responsibilities under the contract. This will include as a minimum the following:

1. Designated persons, qualified by training or experience, to be responsible for the provision of covered services, authorization responsibilities and quality management duties.

2. Beneficiary problem resolution processes.

3. Provider problem resolution and appeal processes.

4. Data reporting capabilities sufficient to provide necessary and timely reports to the Department.

5. Financial records and books of account maintained, using a generally accepted method of accounting, which fully disclose the disposition of all Medi-Cal program funds received.

E. Quality Management

The Contractor shall implement a Quality Management Program in accordance with Title 9, CCR, Section 1810.440 and Appendix A (consisting of three pages) and Appendix B (consisting of two pages), which are incorporated herein by reference, for evaluating the appropriateness and quality of the covered services provided to beneficiaries. References to the mental health plan (MHP) in Appendices A and B are references to the Contractor. The Contractor shall provide the Department with reports generated through the Quality Management Program on request.

The Contractor shall ensure that all covered services delivered by organizational providers are provided under the direction of a physician; a licensed/waivered psychologist; a licensed/registered/waivered social worker; a licensed/registered/waivered marriage and family therapist; or a registered nurse.

The Contractor shall provide the Department with information on the design, progress and outcome of the study of Latino access if required by Exhibit A, Attachment 1, Section E, of the Contractor's Fiscal Year 2002-03 contract with the Department, upon request. If the Contractor was required to complete this

study and has not completed the study, the Contractor may elect to continue the study beyond June 30, 2004. If the Contractor makes this election, the Contractor shall initiate the study prior to January 1, 2004 and shall notify the Department of the Contractor's intent to conduct an extended study. If the Contractor does not make this election, the Contractor shall complete the study by June 30, 2004.

F. Beneficiary Records

The Contractor shall maintain at a site designated by the Contractor for each beneficiary who has received services a legible record kept in detail consistent with Appendix C (consisting of three pages), which is incorporated herein by reference, and good professional practice which permits effective quality management processes and external operational audit processes, and which facilitates an adequate system for follow-up treatment. References to the client in Appendix C are references to beneficiaries who have received services through the Contractor. If a beneficiary receives only psychiatric inpatient hospital services, the Contractor need not maintain a record for the beneficiary in addition to the record maintained by the facility, provided the Contractor and appropriate oversight entities have access to the facility's record as provided in Exhibit E, Section 6, Item D.g.

G. Review Assistance

The Contractor shall provide any necessary assistance to the Department in its conduct of facility inspections and operational reviews of the quality of care being provided to beneficiaries, including providing the Department with any requested documentation or reports in advance of a scheduled on site review. Contractor will correct deficiencies as identified by such inspections and reviews according to the time frames delineated in the resulting reports.

H. Implementation Plan

The Contractor shall comply with the provisions of the Contractor's Implementation Plan for Consolidation of Medi-Cal Specialty Mental Health Services pursuant Title 9, CCR, Section 1810.310 as approved by the Department, including the administration of beneficiary problem resolution processes as required by Title 9, CCR, Section 1850.205. The Contractor shall obtain written approval from the Department prior to making any changes to the Implementation Plan as approved by the Department. The Contractor may implement the changes after 30 calendar days if no notice is received from the Department, as provided in Title 9, CCR, Section 1810.310.

I. Memorandum of Understanding with Medi-Cal Managed Care Plans.

The Contractor shall enter into a Memorandum of Understanding (MOU) with any Medi-Cal managed care plan serving the Contractor's beneficiaries in accordance with Title 9, CCR, Section 1810.370. The Contractor shall notify the Department in writing if the Contractor is unable to enter into an MOU or if an

MOU is terminated, providing a description of the Contractor's good faith efforts to enter into or maintain the MOU.

J. Cultural Competence Plan

The Contractor shall comply with the provisions of the Contractor's Cultural Competence Plan submitted in accordance with Title 9, CCR, Section 1810.410, and approved by the Department. The Contractor shall comply with any changes to Cultural Competence Plan requirements and standards for cultural and linguistic competence established by the Department to be effective during the term of the contract. The Contractor shall provide an update on the Cultural Competence Plan as required by Title 9, CCR, Section 1810.410(c) in a format to be determined by the Department.

K. Certification of Organizational Providers

The Contractor shall certify the organizational providers that subcontract with the Contractor to provide covered services in accordance with Title 9, CCR, Section 1810.435 and the requirements specified in Appendix D (consisting of two pages), which is herein incorporated by reference, prior to the date on which the provider begins to deliver services under the contract, and once every two years after that date, except as provided in Appendix D. The on site review required by Title 9, CCR, Section 1810.435(d) as a part of the certification process, will be made of any site owned, leased, or operated by the provider and used to deliver covered services to beneficiaries, except that on-site review is not required for public school or satellite sites.

The Contractor may allow an organizational provider to begin delivering covered services to beneficiaries at a site subject to on site review prior to the date of the on site review, provided the site is operational and has any required fire clearances. The earliest date the provider may begin delivering covered services at a site subject to on site review is the latest of the date the provider requested certification in accordance with the Contractor's certification procedures, the date the site was operational or the date a required fire clearance was obtained. The Contractor shall complete any required on-site review of a provider's sites within six months of the date the provider begins delivering covered services to beneficiaries at the site.

The Contractor may allow an organizational provider to continue delivering covered services to beneficiaries at a site subject to on site review as part of the biennial recertification process prior to the date of the on site review, provided the site is operational and has any required fire clearances. The Contractor shall complete any required on-site review of a provider's sites within six months of the date the biennial recertification of the provider is due.

Nothing in this section precludes the Department from establishing procedures for issuance of separate provider identification numbers for each of the sites operated by an organizational provider to facilitate the claiming of federal

financial participation by the Contractor and the Department's tracking of that information.

L. Recovery from Other Sources or Providers

The Contractor shall recover the value of covered services rendered to beneficiaries whenever the beneficiaries are covered for the same services, either fully or partially, under any other state or federal medical care program or under other contractual or legal entitlement including, but not limited to, a private group or indemnification program, but excluding instances of the tort liability of a third party or casualty liability insurance. The moneys recovered are retained by the Contractor; however, contractor claims for federal financial participation for services provided to beneficiaries under this contract will be reduced by the amount recovered. Nothing in this section supersedes the Contractor's obligation to follow federal requirements for claiming federal financial participation for services provided to beneficiaries with other coverage under this contract as described in DMH Letter No. 95-01, dated January 31, 1995, or subsequent DMH Letters on this subject.

M. Third-Party Tort and Casualty Liability Insurance

The Contractor shall make no claim for recovery of the value of covered services rendered to a beneficiary when such recovery would result from an action involving the tort liability of a third party or casualty liability insurance including workers' compensation awards and uninsured motorists coverage. The Contractor will identify and notify the State Department of Health Services of cases in which an action by the beneficiary involving the tort or casualty liability of a third party could result in recovery by the recipient of funds to which the State Department of Health Services has lien rights. Such cases will be referred to the State Department of Health Services within 10 days of discovery. To assist the State Department of Health Services in exercising its responsibility for such recoveries, the Contractor will meet the following requirements:

1. If the State Department Health Services requests payment information and/or copies of paid invoices/claims for covered services to a beneficiary, the Contractor will deliver the requested information within 30 days of the request. The value of the covered services will be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to subcontracted providers or out of plan providers for similar services.

2. Information to be delivered will contain the following data items:

    a. Beneficiary name.

    b. Full 14 digit Medi-Cal number.

    c. Social Security Number.

d. Date of birth.

e. Contractor name.

f. Provider name (if different from the Contractor)

g. Dates of service.

h. Diagnosis code and/or description of illness.

I. Procedure code and/or description of services rendered.

j. Amount billed by a subcontractor or out of plan provider to the Contractor (if applicable).

k. Amount paid by other health insurance to the Contractor or subcontractor.

l. Amount and date paid by the Contractor to subcontractor or out of plan provider (if applicable).

m. Date of denial and reasons (if applicable).

3. The Contractor will identify to the State Department of Health Services the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

4. If the Contractor receives any requests by subpoena from attorneys, insurers or beneficiaries for copies of bills, the Contractor will provide the State Department of Health Services with a copy of any document released as a result of such request, and will provide the name and address and telephone number of the requesting party.

5. Information reported to the State Department of Health Services pursuant to this Section will be sent to: State Department of Health Services, Third Party Liability Branch, 591 North 7th Street, Sacramento, California 95814

N. Financial Resources

1. The Contractor shall maintain adequate financial resources to carry out its obligation under this contract.

2. The Contractor shall have sufficient funds on deposit with the Department in accordance with Section 5778(I), W&I Code as the matching funds necessary for federal financial participation to ensure timely payment of claims for inpatient services and associated administrative days if applicable.

O. Financial Report

The Contractor shall report the unexpended funds allocated pursuant to Exhibit B to the Department, using methods and procedures established by the Department, if payments under this contract exceed the cost of covered services, utilization review and administration. The Contractor will not be required to return any excess to the Department.

P. Books and Records

The Contractor shall maintain such books and records necessary to disclose how the Contractor discharged its obligations under this contract. These books and records will disclose the quantity of covered services provided under this contract, the quality of those services, the manner and amount of payment made for those services, the beneficiaries eligible to receive covered services, the manner in which the Contractor administered its daily business, and the cost thereof.

Such books and records will include, but are not limited to, all physical records originated or prepared pursuant to the performance under this contract including working papers; reports submitted to the Department; financial records; all medical and treatment records, medical charts and prescription files; and other documentation pertaining to services rendered to beneficiaries. These books and records will be maintained for a minimum of five years from the termination date of this contract, or, in the event the Contractor has been duly notified that the Department, HHS, or the Comptroller General of the United States, or their duly authorized representatives, have commenced an audit or investigation of the contract, until such time as the matter under audit or investigation has been resolved, whichever is later.

The Contractor agrees to place in each of its subcontracts, which are in excess of $10,000 and utilize State funds, a provision that: “The contracting parties shall be subject to the examination and audit of the Auditor General for a period of three years after final payment under contract (Government Code, Section 8546.7).” The Contractor will also be subject to the examination and audit of the State Auditor General for a period of three years after final payment under contract (Government Code, Section 8546.7).

Q. Transfer of Care

Prior to the termination or expiration of this contract and upon request by the Department, the Contractor will assist the State in the orderly transfer of beneficiaries’ mental health care. In doing this, the Contractor will make available to the Department copies of medical records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of beneficiaries, as determined by the Department. Costs of reproduction will be borne by the Department. In no circumstances will a beneficiary be billed for this service.

R. Department Policy Letters

The Contractor shall comply with policy letters issued by the Department to all Mental Health Plans as defined in Title 9, CCR, Section 1810.226. Policy letters will provide specific details of procedures established by the Department for performance of contract terms when procedures not covered in this agreement are determined to be necessary for performance under this agreement, but are not intended to change the basis and general terms of the contract.

S. Delegation

The Contractor shall ensure that any duties and obligations of the Contractor under this contract that are delegated to subcontracting entities meet the requirements of this contract and any applicable federal or state laws and regulations. The Contractor may delegate any duty or obligation under this contract unless delegation is specifically prohibited by this contract or by applicable federal or state laws and regulations. The Contractor may accept the certification of a provider by another Mental Health Plan or by the Department to meet the Contractor's obligations under Section K. The Department will hold the Contractor responsible for performance of the Contractor's duties and obligations under this contract whether or not the duty or obligation is delegated to a subcontractor or another Mental Health Plan.

T. Fair Hearings

The Contractor shall represent the Contractor's position in fair hearings (as defined in Title 9, CCR, Section 1810.216.1) dealing with beneficiaries' appeals of denials, modifications, deferrals or terminations of covered services. The Contractor shall carry out the final decisions of the fair hearing process with respect to issues within the scope of the Contractor's responsibilities under this contract. Nothing in this section is intended to prevent the Contractor from pursuing any options available for appealing a fair hearing decision.

U. Crosswalk between Provider Coding System

The Contractor shall comply with Title 9, CCR, Section 1840.304 when submitting claims for federal financial participation for services billed by individual or group providers using service codes from the Health Care Financing Administration's Common Procedure Coding System (HCPCS). At such time as the table currently included in Section 1840.304 is deleted from this section, the Contractor shall follow the table issued by the Department as a DMH Information Notice.

V. Beneficiary Brochure and Provider Lists

The Contractor shall provide beneficiaries with a brochure upon request and when a beneficiary first receives a specialty mental health service from the Contractor or its subcontracting providers, including but not limited to an assessment to determine whether medical necessity criteria pursuant to Title 9,

CCR, Section 1830.205 are met. The brochure shall contain a description of the services available; a description of the process for obtaining services, including the Contractor's statewide toll-free telephone number; the availability of a list of the Contractor's providers upon request; a description of the Contractor's beneficiary problem resolution process, including the complaint resolution and grievance processes; and a description of the beneficiary's right to request a fair hearing at any time before, during or within 90 days after the completion of the beneficiary problem resolution process. The description of the right to request a fair hearing shall include the information that a fair hearing may be requested whether or not the beneficiary uses the beneficiary problem resolution process and whether or not the beneficiary has received a notice of action pursuant to Title 9, CCR, Section 1850.210.

The Contractor shall provide beneficiaries with a list of the Contractor's providers upon request. The list shall include the providers' names and addresses and shall include information on the category of services available from each provider. At a minimum the services available from the provider must be categorized as psychiatric inpatient hospital services, targeted case management services and/or all other specialty mental health services. The list may include instructions to the beneficiary explaining how appointments may be scheduled.

W. Compliance with the Requirements of Emily Q v. Bontá

The Contractor shall comply with the provisions of the Final Judgment and Preliminary Injunction issued May 11, 2001, in the case of Emily Q. v. Bontá, Case No. CV 98-4181 AHM (AIJx), United States District Court, Central District of California, that apply to the Contractor as determined by the Department.

X. Reports Required by the Centers for Medicare and Medicaid Services (CMS)

The Contractor shall report to the Department no later than October 1, 2002, the number of children by category who voluntarily changed outpatient mental health providers during Fiscal Year 2001-02.

The Contractor shall report to the Department by October 1, 2002, the number of complaints raised to the Contractor through the Contractor's beneficiary problem resolution processes by category of children with special health care needs, by type of problem resolution process used (complaint process or grievance process) during Fiscal Year 2001-02. The report will include the issue and disposition of each complaint, unless more than 25 complaints were filed. If more than 25 complaints were filed, the report will include by the type of issues raised, the number filed under each type and the disposition by the following categories: granted in full, granted in part, denied.

Children with special health care needs are Medi-Cal beneficiaries under the age of 19 who meet the following criteria:

1. In Medi-Cal aid codes 20, 23, 24, 26, 27, 28, 6A, 60, 63, 64, 65, 66, 67, 68, 6C (Medi-Cal eligibility based on eligibility for Supplemental Security Income/Blind/Disabled)

2. In Medi-Cal aid codes 4K, 4C, 42, 5K, 40, 45 (Medi-Cal eligibility based on eligibility for Foster Care)

3. In Medi-Cal aid codes 03, 04 (Medi-Cal eligibility based on eligibility for Adoption Assistance programs)

4. In Medi-Cal aid codes 6V, 6W, 6X, 6Y (Medi-Cal beneficiaries enrolled in a Home and Community Based Services Model waiver)

5. Receiving services from the California Children's Services program as identified by the local CCS program, if the local CCS program is willing to provide the information, or by the beneficiary listing available to the Contractor on the Contractor's secured website at the Department. If both methods are available to the Contractor, the Contractor may select the identification method. If another method of identification becomes available, the Department will notify the Contractor through a letter to all county mental health directors.

Y. Requirements for Day Treatment Intensive and Day Rehabilitation

1. Authorization and Service Requirements

   The Contractor shall implement the following policies and procedures pertaining to day treatment intensive and day rehabilitation, as defined in Title 9, CCR, Sections 1810.213 and 1810.212 respectively, no later than September 1, 2003:

   The Contractor shall require providers to request an initial mental health plan (MHP) payment authorization, as defined in Title 9, CCR, Section 1810.229, from the Contractor for day treatment intensive and for day rehabilitation. Provider as used in this section includes Contractor staff. The Contractor shall require providers to request MHP payment authorization from the Contractor in advance of service delivery when day treatment intensive or day rehabilitation will be provided for more than five days per week. The Contractor shall require providers to request MHP payment authorization from the Contractor for continuation of day treatment intensive at least every three months and day rehabilitation at least every six months. The Contractor's MHP payment authorization function must meet the criteria of Title 9, CCR, Section 1830.215, except that the Contractor shall not delegate the MHP payment authorization function to providers. In the event that the Contractor is the day treatment intensive or day rehabilitation provider, the Contractor shall assure that the MHP payment authorization function does not include Contractor staff involved in providing day treatment intensive or day rehabilitation.

The Contractor shall require providers to request initial MHP payment authorization from the Contractor for counseling, psychotherapy or other similar therapeutic interventions that meet the definition of mental health services as defined in Title 9, CCR, Section 1810.227, excluding services to treat emergency and urgent conditions as defined in Title 9, CCR, Sections 1810.216 and 1810.253 and excluding therapeutic behavioral services as described in DMH Letter No. 99-03, that will be provided on the same day that day treatment intensive or day rehabilitation is being provided to the beneficiary. The Contractor shall require the providers of these services to request MHP payment authorization from the Contractor for continuation of these services on the same cycle required for continuation of the concurrent day treatment intensive or day rehabilitation for the beneficiary. The Contractor shall not delegate the MHP payment authorization function to the provider of day treatment intensive or day rehabilitation or the provider of the additional services.

In addition to meeting the requirements of Title 9, CCR, Sections 1840.318, 1840.328, 1840.330, 1840.350, and 1840.352, the Contractor shall require that providers of day treatment intensive and day include the following minimum service components in day treatment intensive or day rehabilitation:

a. Community meetings, which mean meetings that occur at a minimum once a day, but may occur more frequently as necessary, to address issues pertinent to the continuity and effectiveness of the therapeutic milieu that may, but are not required to be part of the continuous therapeutic milieu; actively involve staff and clients; for day treatment intensive, include a staff person whose scope of practice includes psychotherapy; for day rehabilitation, include a staff person who is a physician; a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; a registered nurse, a psychiatric technician, a licensed vocational nurse, or a mental health rehabilitation specialist; address relevant items including, but not limited to what the schedule for the day will be, any current event, individual issues clients or staff wish to discuss to elicit support of the group, conflict resolution within the milieu, planning for the day, the week, or for special events, old business from previous meetings or from previous day treatment experiences, and debriefing or wrap-up.

b. A therapeutic milieu, which means a therapeutic program that is structured by the service components described in subsections a. and b. below with specific activities being performed by identified staff; takes place for the continuous scheduled hours of operation for the program (more than four hours for a full-day program and a minimum of three hours for a half-day program); includes staff and activities that teach, model and reinforce constructive interactions; includes peer and staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress; involves clients in the overall program, for example, by providing opportunities to lead community meetings and to provide feedback to peers; includes behavior

management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention.

The therapeutic milieu service components described in subsections 1) and 2) below must be made available during the course of the therapeutic milieu for at least a weekly average of three hours per day for full-day programs and an average of two hours per day for half-day programs. (For example, a full-day program that operates five days per week would need to provide a total of 15 hours for the week; a full-day program that operates for seven days a week would need to provide a total of 21 hours for the week.)

1) Day rehabilitation must include:

   a) Process groups, which are groups facilitated by staff to help clients develop the skills necessary to deal with their individual problems and issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems. Day rehabilitation may include psychotherapy instead of process groups or in addition to process groups.

   b) Skill building groups, which are groups in which staff help clients to identify barriers related to their psychiatric and psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.

   c) Adjunctive therapies, which are non-traditional therapies in which both staff and clients participate that utilize self-expression (art, recreation, dance, music, etc.) as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able to utilize the modality to develop or enhance skills directed towards client plan goals.

2). Day treatment intensive must include:

   a) Skill building groups and adjunctive therapies as described in subsection 1)b) and c) above. Day treatment intensive may also include process groups as described in subsection 1)a) above.

   b) Psychotherapy, which means the use of psychosocial methods within a professional relationship to assist the client or clients to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individuals, groups, or communities in respect to behavior, emotions, and

thinking, in respect to their intrapersonal and interpersonal processes. Psychotherapy must be provided by licensed, registered, or waivered staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention.

c. An established protocol for responding to clients experiencing a mental health crisis. The protocol must assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the client's urgent or emergency psychiatric condition (crisis services). If clients will be referred to crisis services outside the day treatment intensive or day rehabilitation program, the day treatment intensive or day rehabilitation staff must have the capacity to handle the crisis until the client is linked to the outside crisis services.

d. A detailed weekly schedule that is available to clients and, as appropriate, to their families, caregivers or significant support persons a detailed written weekly schedule that identifies when and where the service components of program will be provided and by whom. The written weekly schedule will specify the program staff, their qualifications, and the scope of their responsibilities.

e. Staffing ratios that are consistent with the requirements in Title 9, CCR, Sections 1840.350 and 1840.352, and, for day treatment intensive, that include at least one staff person whose scope of practice includes psychotherapy.

   Program staff may be required to spend time on day treatment intensive and day rehabilitation activities outside the hours of operation and therapeutic milieu, e.g., time for travel, documentation, and caregiver contacts.

   The Contractor shall require that at least one staff person is present and available to the group in the therapeutic milieu for all scheduled hours of operation.

   The Contractor shall require that if day treatment intensive or day rehabilitation staff are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program), a clear audit trail is documented by the provider. The Contractor shall require that there be documentation of the scope of responsibilities for these staff and the specific times in which day treatment intensive or day rehabilitation activities are being performed exclusive of other activities.

f. An expectation that the beneficiary will be present for all scheduled hours of operation for each day. When a beneficiary is unavoidably absent for some part of the hours of operation, the Contractor shall ensure that the

provider receives Medi-Cal reimbursement for day treatment intensive and day rehabilitation for an individual beneficiary only if the beneficiary is present for at least 50 percent of the scheduled hours of operation for that day.

g. Documentation of day treatment intensive and day rehabilitation that meets the documentation standards described in Exhibit A-Attachment 1-Appendix C. For day treatment intensive these standards include daily progress notes on activities and a weekly clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service.

h. At least one contact (face-to-face or by an alternative method (e.g., e-mail, telephone, etc.)) per month with a family member, caregiver or other significant support person identified by an adult client, or one contact per month with the legally responsible adult for a client who is a minor. Adult clients may choose whether or not this service component is done for them. The contacts and involvement should focus on the role of the significant support person in supporting the client's community reintegration. It is expected that this contact will occur outside hours of operation and the therapeutic milieu for day treatment intensive and day rehabilitation.

i. A written program description for day treatment intensive and day rehabilitation. Each provider of these services, including Contractor staff, shall be required to develop and maintain this program description. The written program description must describe the specific activities of the service and reflect each of the required components of the services described in this section. The Contractor shall review the written program description for compliance with this section for individual and group providers that begin delivering day treatment intensive or day rehabilitation on or after September 1, 2003 prior to the date the provider begins delivering day treatment intensive or day rehabilitation. The Contractor shall review the written program description for compliance with this section for individual and group providers that were providing day treatment intensive or day rehabilitation prior to September 1, 2003 no later than June 30, 2004.

2. The Contractor shall retain the authority to set additional higher or more specific standards than those set by in this contract, provided the Contractor's standards are consistent with applicable state and federal laws and regulations and do not prevent the delivery of medically necessary day treatment intensive and day rehabilitation.

3. Implementation of Authorization Requirements

   The Contractor shall implement these MHP payment authorization requirements effective September 1, 2003, for beneficiaries whose initial referral for day treatment intensive or day rehabilitation occurs on or after September 1, 2003. For beneficiaries who were receiving day treatment intensive or day rehabilitation prior to September 1, 2003, the Contractor shall require providers to request MHP payment authorization from the Contractor for continuation of day treatment intensive no later than November 30, 2003 and day rehabilitation no later than March 31, 2004. The Contractor shall require providers to follow the same timelines for MHP payment authorization of mental health services as defined in Title 9, CCR, Section 1810.227, excluding services to treat emergency and urgent conditions as defined in Title 9, CCR, Sections 1810.216 and 1810.253 and excluding therapeutic behavioral services as described in DMH Letter No. 99-03, provided on the same day as day treatment intensive or day rehabilitation.

Z. MHP Payment Authorization Requirements for Therapeutic Behavioral Service

Therapeutic behavioral service (TBS) is an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental specialty mental health service as defined in Title 9, CCR, Section 1810.215. TBS is an intensive one-to-one, short-term outpatient treatment intervention for beneficiaries under age 21 with serious emotional problems or mental illness who are experiencing a stressful transition or life crisis and need additional short-term specific support services. TBS must be needed to prevent placement in a group home at Rate Classification Level (RCL) 12 through 14 or a locked facility for the treatment of mental health needs or to enable a transition from any of those levels to a lower level of residential care.

Effective September 1, 2003, the Contractor shall require providers to request initial and on-going mental health plan (MHP) payment authorization, as defined in Title 9, CCR, Section 1810.229, for TBS as described below. The Contractor shall not delegate the authorization function to providers. Provider as used in this section includes Contractor staff. In the event that the Contractor is the TBS provider, the Contractor shall assure that the authorization process does not include staff involved in providing TBS. The Contractor shall require providers to submit MHP payment authorization requests prior to the end of the specified hours or days in the current authorization period and shall make timely decisions on MHP payment authorization requests to ensure there is no break in medically necessary services to the beneficiary.

When the Contractor's MHP payment authorization decisions result in denial, modification, deferral, reduction or termination of the services requested by the provider, the Contractor shall provide notices of action (NOAs) in accordance with the requirements of Title 9, CCR, Section 1850.210, and, when required by Title 9, CCR, Section 1850.215, the continuation of services pending a fair hearing decision. When applicable, the NOA must advise the beneficiary of the

right to request continuation of previously authorized services pending the outcome of a Medi-Cal fair hearing if the request for hearing is timely.

The MHP payment authorization requirements of this section replace the Contractor's obligations under DMH Letter No. 99-03, page 6, to review the TBS component of a beneficiary's client plan monthly.

1. General Authorization Requirements

    a. The Contractor shall require providers to request MHP payment authorization for TBS in advance of the delivery of the services included in the authorization request.

    b. The Contractor shall make decision on MHP payment authorization requests for TBS in advance of service delivery for the first authorization and subsequent reauthorizations of TBS.

    c. Both the initial authorization and subsequent reauthorization decisions must be made by a licensed practitioner of the healing arts (LPHA) as required by Title 9, CCR, Section 1830.215.

    d. The Contractor shall issue a decision on an MHP payment authorization request for TBS no later than 14 calendar days of receipt of the request.

    e. The Contractor retains the authority to set additional standards necessary to manage the delivery of TBS, including but not limited to establishing maximum hours for individual TBS service components (e.g., assessment, client plan development, and collateral services), provided the Contractor's standards are consistent with applicable state and federal laws and regulations and do not prevent the delivery of medically necessary TBS.

2. Initial Authorization

    The Contractor shall not approve an initial MHP payment authorization request that exceeds 30 days or 60 hours, whichever is less, except as specified in subsection 3.c. below. The initial authorization shall cover the provider conducting an initial TBS assessment, which must identify at least one symptom or behavior TBS will address; developing an initial TBS client plan, which must identify at least one TBS intervention; and providing the initial delivery of direct one-to-one TBS.

3. Reauthorization

    a. The Contractor shall not approve an MHP payment authorization request for reauthorization of TBS that exceeds 60 days or 120 hours, whichever is less.

b. If the Contractor approved a provider's initial MHP payment authorization request under the provisions of subsection 2. above, the Contractor shall not approve the provider's first request for reauthorization unless the provider's request includes a TBS client plan that meets the following criteria:

   1) A TBS client plan may be a separate client plan for the delivery of TBS or a component of a more comprehensive client plan. The TBS client plan is intended to provide clinical direction for one or a series of short-term intervention(s) to address very specific behaviors and/or symptoms of the beneficiary as identified by the assessment process.

   2) Clearly specified behaviors and/or symptoms that jeopardize the residential placement or transition to a lower level of residential placement and that will be the focus of TBS.

   3) A specific plan of intervention for each of the targeted behaviors or symptoms identified in the assessment and the client plan.

   4) A specific description of the changes in the behaviors and/or symptoms that the interventions are intended to produce, including a time frame for these changes.

   5) A specific way to measure the effectiveness of the intervention at regular intervals and documentation of changes in planned interventions when the original plans are not achieving expected results.

   6) A transition plan that describes in measurable terms how and when TBS will be decreased and ultimately discontinued, either when the identified benchmarks (which are the objectives that are met as the beneficiary progresses towards achieving client plan goals) have been reached or when reasonable progress towards goals is not occurring and, in the clinical judgment of the individual or treatment team developing the plan, are not reasonably expected to be achieved. This plan should address assisting parents/caregivers with skills and strategies to provide continuity of care when TBS is discontinued.

   7) As necessary, a plan for transition to adult services when the beneficiary turns 21 years old and is no longer eligible for TBS. This plan should also address assisting parents/caregivers with skills and strategies to provide continuity of care when this service is discontinued, when appropriate in the individual case.

   8) If the beneficiary is between 18 and 21 years of age, notes regarding any special considerations that should be taken into account, e.g., the identification of an adult case manager.

c. When the provider's initial request for MHP payment authorization includes a completed TBS assessment and TBS client plan that meets the requirements of subsection b.1) through 7), the Contractor may authorize TBS services consistent with the limits of this section, i.e., an initial MHP payment authorization request that covers direct one-to-one TBS that are fully supported by an assessment and TBS client plan may be approved for 60 days or 120 hours, whichever is less.

d. The Contractor shall base decisions on MHP payment authorization requests for reauthorization of TBS on clear documentation of the following and any additional information from the TBS provider required by the Contractor:

1) The beneficiary's progress towards the specific goals and timeframes of the TBS client plan. A strategy to decrease the intensity of services and/or to initiate the transition plan and/or terminate services when TBS has been effective for the beneficiary in making progress towards specified measurable outcomes identified in the TBS plan or the beneficiary has reached a plateau in benefit effectiveness.

2) If applicable, the beneficiary's lack of progress towards the specific goals and timeframes of the TBS client plan and changes needed to address the issue. If the TBS being provided to the beneficiary has not been effective and the beneficiary is not making progress as expected towards identified goals, the alternatives considered and the reason that only the approval of the requested additional hours/days for TBS instead of or in addition to the alternatives will be effective.

3) The review and updating of the TBS client plan as necessary to address any significant changes in the beneficiary's environment (e.g., a change in residence).

4) The provision of skills and strategies to parents/caregivers to provide continuity of care when TBS is discontinued.

f. When the Contractor approves a fourth MHP payment authorization request for a beneficiary, the Contractor shall provide a summary of the TBS services provided, justification for the additional authorization and a termination plan with clearly established timelines and benchmarks, including a planned date for termination of TBS, in writing to the Mental Health Director for the Contractor and to the Deputy Director, Systems of Care, Department of Mental Health, within five working days of the authorization decision.

4. Implementation of Authorization Requirements

The Contractor shall implement these MHP payment authorization requirements effective September 1, 2003, for beneficiaries whose initial referral for TBS occurs on or after September 1, 2003. For beneficiaries who

were receiving direct one-to-one TBS or who had been referred to a provider that would provide both the initial assessment of the need for TBS and direct one-to-one TBS prior to September 1, 2003, the Contractor shall complete the reauthorization for on-going TBS by November 1, 2003.

AA. Program Integrity Requirements

Effective August 13, 2003 the Contractor shall initiate the process for compliance with Title 42, Code of Federal Regulations (CFR), Section 438.608. The Contractor shall provide the Department will a written statement of the Contractor's progress in implementing the requirement no later than October 15, 2003 and an update on progress on January 15, 2004 and April 15, 2004. Title 42, CFR, Section 438.608, in which the Contractor is a PIHP (Prepaid Inpatient Health Plan), provides:

Sec. 438.608 Program integrity requirements.
(a) General requirement. The MCO or PIHP must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.
(b) Specific requirements. The arrangements or procedures must include the following:
(1) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards.
(2) The designation of a compliance officer and a compliance committee that are accountable to senior management.
(3) Effective training and education for the compliance officer and the organization's employees.
(4) Effective lines of communication between the compliance officer and the organization's employees.
(5) Enforcement of standards through well-publicized disciplinary guidelines.
(6) Provision for internal monitoring and auditing.
(7) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's or PIHP's contract.